		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041376

Facility Name: Parkview Care Center

Address: 301 East Garland (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: 618 937-2428 **Fax #** 618 937-1465

IDPA ID Number: 371352269001

Date of Initial License for Current Owners: 2/23/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: F. Micheal Bridges **Telephone Number:** 618 257-1150

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 04/30/03 (Date)
(Type or Print Name) F. Micheal Bridges
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	21,535	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	59	21,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,780	4,749	336	17,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,780	4,749	336	17,865	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.96%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	86,271	9,250	3,963	99,484		99,484		99,484			1
2	Food Purchase		86,373		86,373		86,373	(721)	85,652			2
3	Housekeeping	45,613	5,322		50,935		50,935		50,935			3
4	Laundry	38,040	2,535	1,740	42,315		42,315		42,315			4
5	Heat and Other Utilities			39,628	39,628		39,628	440	40,068			5
6	Maintenance	24,532	1,107	12,355	37,994		37,994	420	38,414			6
7	Other (specify):*											7
8	**TOTAL General Services**	194,456	104,587	57,686	356,729		356,729	139	356,868			8
	B. Health Care and Programs											
9	Medical Director			3,250	3,250		3,250		3,250			9
10	Nursing and Medical Records	434,458	18,848	398	453,704		453,704		453,704			10
10a	Therapy											10a
11	Activities	17,453	1,890	2,012	21,355		21,355		21,355			11
12	Social Services	19,390		1,968	21,358		21,358		21,358			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	471,301	20,738	7,628	499,667		499,667		499,667			16
	C. General Administration											
17	Administrative	39,998		84,409	124,407		124,407	(46,125)	78,282			17
18	Directors Fees											18
19	Professional Services			6,237	6,237		6,237	14,288	20,525			19
20	Dues, Fees, Subscriptions & Promotions			112	112		112	438	550			20
21	Clerical & General Office Expenses	3,419	2,571	49,168	55,158		55,158	23,632	78,790			21
22	Employee Benefits & Payroll Taxes			109,084	109,084		109,084	12,098	121,182			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,054	1,054		1,054	826	1,880			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,133	1,133		1,133	831	1,964			26
27	Other (specify):*											27
28	**TOTAL General Administration**	43,417	2,571	251,197	297,185		297,185	5,988	303,173			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	709,174	127,896	316,511	1,153,581		1,153,581	6,127	1,159,708			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Parkview Care Center #0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,456	2,456		2,456		2,456			30
31	Amortization of Pre-Op. & Org.			1,572	1,572		1,572		1,572			31
32	Interest											32
33	Real Estate Taxes			19,174	19,174		19,174		19,174			33
34	Rent-Facility & Grounds			95,271	95,271		95,271	2,419	97,690			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			118,473	118,473		118,473	2,419	120,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,922	600	3,522		3,522		3,522			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,362	32,362		32,362		32,362			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,922	32,962	35,884		35,884		35,884			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	709,174	130,818	467,946	1,307,938		1,307,938	8,546	1,316,484			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(721)	2		4
5	Telephone, TV & Radio in Resident Rooms	(410)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,471)	21		18
19	Entertainment	(765)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,574)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,941)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	24,487		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,487		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 8,546		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Parkview Care Center

ID# 0041376

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(721)	0	0	0	0	0	0	0	0	0	0	(721)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(410)	850	0	0	0	0	0	0	0	0	0	440	5
6	Maintenance	0	420	0	0	0	0	0	0	0	0	0	420	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,131)	1,270	0	0	0	0	0	0	0	0	0	139	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(46,125)	0	0	0	0	0	0	0	0	0	(46,125)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,288	0	0	0	0	0	0	0	0	0	14,288	19
20	Fees, Subscriptions & Promotions	0	438	0	0	0	0	0	0	0	0	0	438	20
21	Clerical & General Office Expenses	(14,810)	38,442	0	0	0	0	0	0	0	0	0	23,632	21
22	Employee Benefits & Payroll Taxes	0	12,098	0	0	0	0	0	0	0	0	0	12,098	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	826	0	0	0	0	0	0	0	0	0	826	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	831	0	0	0	0	0	0	0	0	0	831	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,810)	20,798	0	0	0	0	0	0	0	0	0	5,988	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,941)	22,068	0	0	0	0	0	0	0	0	0	6,127	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkview Care Center # 0041376 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	2,419	0	0	0	0	0	0	0	0	0	2,419	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	2,419	0	0	0	0	0	0	0	0	0	2,419	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,941)	24,487	0	0	0	0	0	0	0	0	0	8,546	45

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
F. Micheal Bridges	50.00%	Parkview Health Care Center	West Frankfort	Lakeland Health		
Billie Jo Bridges	50.00%	Frankfort Health Care Center	West Frankfort	Care, Inc.	Trenton	Mgmt. Co.
		Olney Health Care Center	Olney			
				Sugar Creek		
				Health Care	Trenton	Mgmt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 84,409	Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	$	$ (84,409)	1
2	V	5	Utilities		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	850	850	2
3	V	6	Repairs, maint. & security		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	420	420	3
4	V	19	Professioanl Fees		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	14,288	14,288	4
5	V	20	Dues and subscriptions		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	438	438	5
6	V	22	Employee benefits		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	12,098	12,098	6
7	V	24	Travel & seminar		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	826	826	7
8	V	26	Insurance - Property		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	831	831	8
9	V	34	Rent - Bldg		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	2,419	2,419	9
10	V	21	Office Supplies		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	8,013	8,013	10
11	V	17	Admin Salary		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	38,284	38,284	11
12	V	21	Clerical		Lakeland Health Care, Inc. / Sugar Creek Health Care	100.00%	30,429	30,429	12
13	V								13
14	Total			$ 84,409			$ 108,896	$ * 24,487	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	F. Micheal Bridges	CEO	Administrative	50.00	64,325	12	20.00	Wages	$ 13,675	17-7	1
2	Billie Jo Bridges	Vice-President	Administrative	50.00	45,294	12	20.00	Wages	9,629	17-7	2
3	Micheal J. Bridges	COO	Administrative	0.00	46,595	12	20.00	Wages	9,905	17-7	3
4	Nicholas Bridges	AIT	Administrative	0.00	23,915	12	20.00	Wages	5,085	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 38,294		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Parkview Care Center Sch VII
Provider #0041376 01/01/02-12/31/02

Owner and related party wages		Total	Olney	Parkview	Frankfort	Caremore	Coulterville	Camelot
Bridges, F. Micheal	Owner 50%	78,000	17,131	13,675	14,370	18,894	9,836	4,095
Bridges, Billie J.	Owner 50%	54,923	12,062	9,629	10,118	13,303	6,927	2,883
Bridges, Micheal J.	Son	56,500	12,408	9,905	10,408	13,685	7,126	2,967
Bridges, Nicholas	Son	29,000	6,369	5,085	5,343	7,024	3,657	1,523
		218,423	47,971	38,295	40,239	52,906	27,545	11,468

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sugar Creek Health Care
Street Address: 439 E. Broadway
City / State / Zip Code: Trenton, IL 62293
Phone Number: (618 257-1150
Fax Number: (618 257-1157

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient days	101,925	6	$ 4,849	$	17,865	$ 850	1
2	6	Repairs, maint. & security	Patient days	101,925	6	2,397		17,865	420	2
3	19	Professional fees	Patient days	101,925	6	81,518		17,865	14,288	3
4	20	Dues & subscriptions	Patient days	101,925	6	2,500		17,865	438	4
5	21	Office supplies	Patient days	101,925	6	45,714		17,865	8,013	5
6	22	Employee benefits	Patient days	101,925	6	69,020		17,865	12,098	6
7	24	Travel & seminar	Patient days	101,925	6	4,711		17,865	826	7
8	34	Rent - Bldg.	Patient days	101,925	6	13,800		17,865	2,419	8
9	17	Admin Salary	Patient days	101,925	6	218,423	218,423	17,865	38,284	9
10	21	Clerical & general office exp	Patient days	101,925	6	173,607	173,607	17,865	30,429	10
11	26	Insurance - Property	Patient days	101,925	6	4,740		17,865	831	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 621,279	$ 392,030		$ 108,896	25

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,174	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 19,174	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	16,644	8
	1998	25,140	9
	1999	25,269	10
	2000	18,484	11
	2001	19,174	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkview Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0041376

CONTACT PERSON REGARDING THIS REPORT F. Micheal Bridges

TELEPHONE 618 257-1150 FAX #: 618 257-1157

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached		$ 19,174.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,174.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,796 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 31,429
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 1,572
4. Dates Incurred: 2/96

Nature of Costs: Organizational Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Driveway			1996	1,655	127	15	127		890	9
10	Room Remodeling			1996	1,388	36	36	36		234	10
11	Security System			1997	899	79	7	79		899	11
12	Hot Water Heater			1997	4,260	373	7	373		4,260	12
13	Securtiy System			1998	5,399	138	39	138		662	13
14	Room Remodeling			2001	935	24	39	24		24	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 14,536	$ 777		$ 777	$	$ 6,969	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 19,580	$ 1,681	$ 1,681	$		$ 16,541	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 19,580	$ 1,681	$ 1,681	$		$ 16,541	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 34,116	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 2,458	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 23,510	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		59	2/1/96	$ 114,445	20	10	3
4	Additions							4
5	Mgmt Co Allocation				2,419			5
6								6
7	TOTAL		59		$ 116,864 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: $18,000 per bed *

10. Effective dates of current rental agreement:
Beginning 2/1/96
Ending 2/1/2116

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 114,445
13.	/2004	$ 114,445
14.	/2005	$ 114,445

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 0 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Parkview Care Center **#** 0041376 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,556	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 39,445)	134,215		3
4	Supply Inventory (priced at)	3,133		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,347		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 147,251	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	14,536		15
16	Equipment, at Historical Cost	19,580		16
17	Accumulated Depreciation (book methods)	(23,510)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	31,429		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,870)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 31,165	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 178,416	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 240,983	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,664		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,349		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	607,500		36
37	Accrued Management Fees	193,141		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,123,637	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,123,637	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (945,221)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 178,416	$	48

***(See instructions.)**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (842,783)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (842,783)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(102,438)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (102,438)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (945,221)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,204,780	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,204,780	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	721	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 721	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,205,501	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	356,729	31
32	Health Care	499,667	32
33	General Administration	297,186	33
	B. Capital Expense		
34	Ownership	118,473	34
	C. Ancillary Expense		
35	Special Cost Centers	3,522	35
36	Provider Participation Fee	32,362	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,307,939	40
41	**Income before Income Taxes (line 30 minus line 40)****	(102,438)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (102,438)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Parkview Care Center
December 31, 2002

Reconciliation of Book to Tax Income

The tax return is not yet completed

Anticipated reconciling items are:

Depreciation - book vs. tax
Bad debts - book vs. tax
Meals & entertainment - allowable tax deduction

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,967	2,068	$ 35,160	$ 17.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	360	385	5,397	14.02	3
4	Licensed Practical Nurses	12,247	12,709	157,668	12.41	4
5	Nurse Aides & Orderlies	29,573	30,219	236,233	7.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,381	2,469	17,453	7.07	9
10	Activity Assistants					10
11	Social Service Workers	1,975	1,999	19,390	9.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,923	2,010	24,724	12.30	14
15	Cook Helpers/Assistants	8,941	9,605	61,547	6.41	15
16	Dishwashers					16
17	Maintenance Workers	1,996	2,044	24,532	12.00	17
18	Housekeepers	7,542	7,835	45,613	5.82	18
19	Laundry	6,651	6,847	38,041	5.56	19
20	Administrator	1,960	2,080	39,998	19.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	585	605	3,419	5.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,101	80,875	$ 709,175 *	$ 8.77	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	98	$ 3,226	1-3	35
36	Medical Director	monthly	3,250	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,968	11-3	44
45	Social Service Consultant	44	1,968	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	186	$ 11,012		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brenda Dunn	Administrator	0.00	$ 39,998
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 39,998

B. Administrative - Other

Description	Amount
Lakeland Health Care, Inc. - Management Fees	$ 84,409
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 84,409

C. Professional Services

Vendor/Payee	Type	Amount
Kerber, Eck & Braeckel, LLP	Cost Reports	$ 3,853
Paul Durr	Legal Fees	2,383
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 6,236

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,724
Unemployment Compensation Insurance	13,647
FICA Taxes	54,252
Employee Health Insurance	13,462
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Management Company Allocation	12,098
TOTAL (agree to Schedule V, line 22, col.8)	$ 121,183

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	112
Health Care Worker Background Check (Indicate # of checks performed)	
Management Company Allocation	438
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 550

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,014
Seminar Expense	40
Management Company Allocation	826
Entertainment Expense	(765)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,115

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Parkview Care Center # 0041376 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **n/a**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,042** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,362**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **721**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.